SERIES 4

UNICARE STATE INDEMNITY PLAN/PLUS

Benefit Updates and Important Information For Active Employees and Non-Medicare-Eligible Retirees

Effective February 1, 2010

UniCare®

Commonwealth of Massachusetts
Group Insurance Commission

Updates to the UniCare State Indemnity Plan/PLUS Member Handbook

This *Benefit Updates and Plan Information* booklet ("Benefit Update") contains important updates to your UniCare State Indemnity Plan/PLUS coverage, effective February 1, 2010. Please keep this Benefit Update—together with the Series 4 Member Handbook ("Member Handbook")—in a convenient place for easy access when you need to check your health plan information.

This Benefit Update is also available on the Plan's website: visit **www.unicarestateplan.com** > "Members" > "Forms and Documents." The updates in this Benefit Update will also be incorporated into the next printed version of your Member Handbook.

If you have any questions about these changes, please call UniCare Customer Service at (800) 442-9300, Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. You can also e-mail us from our website: **www.unicarestateplan.com** (click on "Contact Us"). If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A UniCare customer service representative will be happy to help you.

Note: Page references and references to appendices in this Benefit Update refer to pages in your Member Handbook unless otherwise indicated.

Calendar Year Deductibles

Beginning February 1, 2010, you must meet a calendar year deductible for most covered services when you use PLUS providers before your health plan begins paying benefits for you or your dependent(s). This deductible is in addition to the existing calendar year deductible when you use non-PLUS providers. The calendar year deductible when using PLUS providers is $250 per member and $750 per family. The two calendar year deductibles you must satisfy when you use PLUS and non-PLUS providers are shown in the chart on page 6 of this Benefit Update.

Different services are subject to the calendar year deductible, depending on whether they are rendered by PLUS or non-PLUS providers. See the Summary of Covered Services charts on pages 7-15 of this Benefit Update to see where the calendar year deductible applies for each type of service.

The following changes are made to your Member Handbook to reflect the new calendar year deductible when you use PLUS providers:

A. The "Deductibles" subsection on pages 6-8 in the "Your Costs" section of your Member Handbook is deleted and replaced with the text below. This subsection has been renamed, "Calendar Year Deductibles."

Note: Information about the inpatient hospital quarterly deductible and the outpatient surgery quarterly deductible is deleted from the "Deductibles" subsection and added to the updated "Copayments" subsection on pages 16-19 of this Benefit Update. These amounts are now referred to as copays rather than deductibles.

Calendar Year Deductibles

The calendar year deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or for a covered dependent. The calendar year deductible amounts you must satisfy are shown in the chart on page 6 of this Benefit Update.

With the PLUS Plan, you have two separate calendar year deductibles:

1. **When you use PLUS providers (which include Preferred Vendors)** – PLUS providers consist of all Massachusetts providers (except for non-Preferred Vendors), and non-Massachusetts providers in the UniCare provider network.
2. **When you use non-PLUS providers or non-Preferred Vendors** – Non-PLUS providers are providers outside Massachusetts that are not part of the UniCare provider network.

Individual Calendar Year Deductibles

The individual calendar year deductible is the amount you must pay before benefits for many services begin for that calendar year. In addition to meeting the individual calendar year deductible, you continue to be responsible for copays and coinsurance amounts, where applicable. For updated copay amounts, see the chart on pages 18-19 of this Benefit Update.

Individual Calendar Year Deductible with PLUS Providers

Example: If you go to a **PLUS** provider for a medical problem in January, you will have to pay the applicable copay and then $250 of the Allowed Amount. If your provider charges less than $250, the balance of the deductible will be taken from your next service. If there are remaining charges after the deductible, then, depending on the service provided, the Plan pays either 100% of the Allowed Amount, or 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the $250 calendar year deductible, you will not have to pay it again for the remainder of the calendar year for any services you receive from PLUS providers. However, if you receive services from non-PLUS providers, you will be responsible for a separate individual calendar year deductible for non-PLUS providers. (See "Individual Calendar Year Deductible with non-PLUS Providers" on page 5 of this Benefit Update for details.)

The Plan determines the providers to whom you owe the deductible based on the order in which the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe deductible amounts for any services you receive from PLUS providers.

The PLUS calendar year deductible applies to most medical services you receive from PLUS providers. Check the Summary of Covered Services charts on pages 7-15 of this Benefit Update to see where the PLUS calendar year deductible is applied when you use PLUS providers.

Individual Calendar Year Deductible with Non-PLUS Providers

Example: If you go to a **non-PLUS** provider for a medical problem in January, you will have to pay the office visit copay and then $100 of the Allowed Amount. If your provider charges less than $100, the balance of the deductible will be taken from your next visit. If there are remaining charges after the deductible, then, depending on the service provided, the Plan pays either 100% of the Allowed Amount, or 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the $100 calendar year deductible, you will not have to pay it again for any services you receive from non-PLUS providers for the remainder of the calendar year. However, if you receive services from PLUS providers, you will be responsible for a separate individual calendar year deductible for PLUS providers. (See "Individual Calendar Year Deductible with PLUS Providers" on pages 4-5 of this Benefit Update for details.)

The Plan determines the providers to whom you owe the deductible based on the order in which the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe deductible amounts for any services you receive from non-PLUS providers.

The calendar year deductible applies to most medical services you receive from non-PLUS providers. Check the Summary of Covered Services charts on pages 7-15 of this Benefit Update to see the services to which the calendar year deductible applies when you use non-PLUS providers.

Family Calendar Year Deductibles

If you have family coverage and use either PLUS or non-PLUS providers, a deductible will apply to your family in any calendar year. The family calendar year deductible is a maximum dollar amount your family must pay before benefits for many services begin for that calendar year.
In addition to meeting the family calendar year deductible, you and your dependent(s) continue to be responsible for copays and coinsurance amounts, where applicable. For updated copay amounts, see the chart on pages 18-19 of this Benefit Update.

Family Calendar Year Deductible with PLUS Providers

The maximum each person in the family must satisfy is $250 until the family as a whole reaches the $750 maximum.

Example: You, your spouse and your three children have family coverage under the PLUS Plan. You and your three children go to PLUS providers for medical care in January. Three of you pay $200 deductibles and one of you pays a $150 deductible. Even though no one individual family member has met the $250 deductible, the family deductible of $750 has been met. Therefore, no additional calendar year deductible will apply to your family for that calendar year. However, if you or members of your family receive services from non-PLUS providers, you will be responsible for a separate calendar year deductible for non-PLUS providers. (See "Family Calendar Year Deductible with non-PLUS Providers" on page 6 of this Benefit Update for details.)

Family Calendar Year Deductible with Non-PLUS Providers
The maximum each person in the family must satisfy is $100 until the family as a whole reaches the $200 maximum.

Example: You, your spouse and your three children have family coverage under the PLUS Plan. You and two of your children go to non-PLUS providers for medical care in January. Two of you pay $75 deductibles and one of you pays a $50 deductible.

Even though no one individual family member has met the $100 deductible, the family deductible of $200 has been met. Therefore, no additional calendar year deductible will apply to your family for that calendar year. However, if you or members of your family receive services from PLUS providers, you will be responsible for a separate calendar year deductible for PLUS providers. (See "Family Calendar Year Deductible with PLUS Providers" on page 5 of this Benefit Update for details.)

Calendar Year Deductibles	When You Use a PLUS Provider	When You Use a Non-PLUS Provider
Individual Calendar Year Deductible	$250 per calendar year	$100 per calendar year
Family Calendar Year Deductible	$750 per calendar year If you have family coverage, $750 in deductibles will apply to your family in any calendar year. The deductible for an individual family member will not exceed $250.	$200 per calendar year If you have family coverage, $200 in deductibles will apply to your family in any calendar year. The deductible for an individual family member will not exceed $100.

B. The Summary of Covered Services charts in the "Benefits Highlights" section on pages 28-36 of your Member Handbook are deleted and replaced with the following charts. **Note:** The page references in the third column of these charts, as well as the page references to appendices elsewhere in these charts, refer to pages in your Member Handbook unless otherwise indicated.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
☎ Inpatient Hospital Services in an Acute Medical, Surgical or Rehabilitation Facility		📖 Also see page 37
Semi-Private Room, ICU, CCU and Ancillary Services	100% after the inpatient hospital quarterly copay and after the calendar year deductible	80% after the inpatient hospital quarterly copay
Medically Necessary Private Room	100% for the first 90 days in a calendar year after the inpatient hospital quarterly copay and after the calendar year deductible; then 100% at the semi-private level	80% for the first 90 days in a calendar year after the inpatient hospital quarterly copay; then 80% at the semi-private level. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Inpatient Diagnostic Laboratory and Radiology (including high-tech imaging)	100% after the calendar year deductible	80%
☎ Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs (See Appendix D for list of procedures and hospitals.)		📖 Also see page 52
Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs	100% after the inpatient hospital quarterly copay and after the calendar year deductible at a Designated Hospital	80% after the inpatient hospital quarterly copay

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
☎ Transplant Services		📖 Also see pages 43-44
Quality Centers and Designated Hospitals for Transplants	100% after the inpatient hospital quarterly copay and after the calendar year deductible	100% after the inpatient hospital quarterly copay
Other Hospitals	80% after the inpatient hospital quarterly copay and after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the inpatient hospital quarterly copay. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Other Inpatient Facilities		📖 Also see page 37
▪ Sub-Acute Care Hospitals/Facilities ▪ Transitional Care Hospitals/Facilities ▪ Long-Term Care Hospitals/Facilities ▪ Chronic Disease Hospitals/Facilities ▪ Skilled Nursing Facilities	80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Emergency Treatment for an Accident / Sudden Serious Illness		📖 Also see pages 37-38
Emergency Room Charge	100% after the emergency room copay and after the calendar year deductible; copay waived if admitted	100% after the emergency room copay; copay waived if admitted
Radiology (including high-tech imaging)	100% after the calendar year deductible	100%
Diagnostic Laboratory Testing	100% after the calendar year deductible	100%

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For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Non-Emergency Treatment		Also see pages 37-38
Emergency Room Charge	100% after the emergency room copay and after the calendar year deductible; copay waived if admitted	100% after the emergency room copay and after the calendar year deductible; copay waived if admitted
Radiology:		
☎ High-Tech Imaging (such as MRIs, CT scans and PET scans)	100% after the copay per scan and after the calendar year deductible; maximum of one copay per day	80% after the copay per scan; maximum of one copay per day
All Other Radiology	100% after the calendar year deductible	80%
Diagnostic Laboratory Testing	100% after the calendar year deductible	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
☎ **Surgery**		Also see page 38
Inpatient Surgery	100% after the calendar year deductible	80%
Outpatient Surgery at a Hospital	100% after the outpatient surgery quarterly copay and after the calendar year deductible	80% after the outpatient surgery quarterly copay
Surgery at an Ambulatory Surgical Facility or Physician's Office	100% after the calendar year deductible	80%

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Outpatient Medical Care		Also see pages 38-43
For Services at a Hospital (other than the services listed below)	100% after the calendar year deductible	80% after the calendar year deductible
Diagnostic Laboratory Testing	100% after the calendar year deductible	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Radiology:		
☎ High-Tech Imaging (such as MRIs, CT scans and PET scans)	100% after the copay per scan and after the calendar year deductible; maximum of one copay per day	80% after the copay per scan; maximum of one copay per day
All Other Radiology	100% after the calendar year deductible	80%
Licensed Retail Medical Clinics at Retail Pharmacies	100% after the copay	80% after the copay and after the calendar year deductible
☎ Physical Therapy and ☎ Occupational Therapy	100% after the copay	100% after the copay and after the calendar year deductible
Speech Therapy	100% up to a maximum benefit of $2,000 per calendar year	80% after the calendar year deductible, up to a maximum benefit of $2,000 per calendar year
Chemotherapy	100% after the calendar year deductible	80% after the calendar year deductible

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Physician Services		Also see page 42
Non-Emergency Treatment at Home, Office or Outpatient Hospital	100% after the applicable office visit copay	80% after the applicable office visit copay and after the calendar year deductible
Hospital Inpatient	100% after the calendar year deductible	80%
Emergency Treatment	100% after the calendar year deductible	100%
☎ Chiropractic Care or Treatment	80% after the chiropractic visit copay; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the chiropractic visit copay and after the calendar year deductible; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the calendar year deductible or the out-of-pocket maximum.
☎ Private Duty Nursing		Also see page 43
Provided in Home Setting Only	80% after the calendar year deductible for a registered nurse, up to a calendar year maximum benefit of $8,000. Of this $8,000, up to $4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible for a registered nurse, up to a calendar year maximum benefit of $8,000. Of this $8,000, up to $4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
☎ Home Health Care		Also see pages 40-41
Medicare Certified Home Health Agencies and Visiting Nurse Associations[1]	80% after the calendar year deductible	80% after the calendar year deductible

1 A program is available to enhance the benefit for Home Health Care by using designated providers. Check our list of Preferred Vendors at www.unicarestateplan.com > "Find a Provider" > "All Provider Listings," or call the Andover Service Center at (800) 442-9300 for more information.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
☎ Home Infusion Therapy		📖 Also see page 54
	100% after the calendar year deductible with a Preferred Vendor[1] 80% after the calendar year deductible with a non-Preferred Vendor. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Preventive Care For information on covered preventive laboratory services and for office visit frequency limits, see pages 42-43.		📖 Also see pages 42-43
Office Visits	100% after the applicable office visit copay	80% after the applicable office visit copay
Annual Gynecological Visits	100% after the applicable office visit copay	80% after the applicable office visit copay
Immunizations	100%	100%
Colonoscopies[2]	100% after outpatient surgery quarterly copay	80% after outpatient surgery quarterly copay
Mammograms[2]	100%	80%
Pap Smears[2]	100%	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Bone Density Testing	100% after the calendar year deductible	80%
Covered Laboratory Testing	100% after the calendar year deductible	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

1 💻 For a list of the Plan's Preferred Vendors, go to www.unicarestateplan.com > "Find a Provider" > "All Provider Listings," or call the Andover Service Center at (800) 442-9300.

2 Colonoscopies, mammograms and Pap smears are subject to the calendar year deductible when performed for diagnostic (non-preventive) purposes.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Hospice		Also see page 44
Medicare Certified Hospice	100% after the calendar year deductible	80% after the calendar year deductible
Bereavement Counseling	80% after the calendar year deductible, up to a maximum benefit of $1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible, up to a maximum benefit of $1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Early Intervention Services for Children		Also see page 40
Programs Approved by the Department of Public Health	80% after the calendar year deductible, up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Ambulance		Also see page 38
	100% after the calendar year deductible	100% of the first $25; then 80% after the calendar year deductible
Coronary Artery Disease (CAD) Secondary Prevention Program		Also see page 26
Designated Programs Available through Medical Case Management	90% after the calendar year deductible. The 10% coinsurance amount does not count toward the out-of-pocket maximum.	Not covered
All Other Programs	Not covered	Not covered

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
☎ Durable Medical Equipment (DME)		Also see page 45
	100% after the calendar year deductible with a Preferred Vendor[1] 80% after the calendar year deductible with a non-Preferred Vendor. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Hospital-Based Personal Emergency Response Systems (PERS)		Also see page 45
Installation	80% after the calendar year deductible, up to a maximum benefit of $50. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible, up to a maximum benefit of $50. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Rental Fee	80% after the calendar year deductible, up to a maximum benefit of $40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible, up to a maximum benefit of $40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Prostheses[2]		Also see page 43
	80% after the calendar year deductible	80% after the calendar year deductible
Braces[3]		Also see page 39
	80% after the calendar year deductible	80% after the calendar year deductible

1 For a list of the Plan's Preferred Vendors, go to www.unicarestateplan.com > "Find a Provider" > "All Provider Listings," or call the Andover Service Center at (800) 442-9300. If an item is not available through a Preferred Vendor and you obtain it from another provider, it will be covered at 80%.

2 Breast prostheses are covered at 100% after the calendar year deductible when you use either a PLUS or a non-PLUS provider. Wigs are not subject to the calendar year deductible when you use PLUS providers.

3 Orthopedic shoe(s) with attached brace is covered at 100% after the calendar year deductible (PLUS or non-PLUS).

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services

	PLUS Provider	Non-PLUS Provider
Hearing Aids		Also see page 40
	100% of the first $500; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum.	100% of the first $500 after the calendar year deductible; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum.
Eyeglasses / Contact Lenses		Also see page 51
	80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery.	80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery.
Routine Eye Examinations (including refraction)		Also see pages 49 & 51
	100% after the applicable copay. Covered once every 24 months.	80% after the applicable copay. Covered once every 24 months.
Family Planning Services		Also see page 40
Office Visits	100% after the applicable office visit copay	100% after the applicable office visit copay and after the calendar year deductible
Procedures	100% after the calendar year deductible	100% after the calendar year deductible
All Other Covered Medical Services		Also see pages 38-46
	80% after the calendar year deductible	80% after the calendar year deductible

For deductible and copay amounts, see the charts on pages 6, 18 and 19 of this Benefit Update. If you receive services from both PLUS and non-PLUS providers, you are responsible for both the PLUS and non-PLUS calendar year deductibles. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Copays for Medical Services

Copay Changes

Beginning February 1, 2010, copays for the following services are changed:

- Physician office visits
- Licensed retail medical clinics at retail pharmacies
- Services provided by nurse practitioners
- Routine eye exams
- Physical therapy and occupational therapy (with PLUS providers only)
- Chiropractic care
- Family planning services office visits
- Emergency room charge
- Outpatient surgery
- Outpatient high-tech imaging, such as MRIs, CT scans and PET scans

For changes to office visit copays for mental health, substance abuse and Employee Assistance Programs, see page 21 of this Benefit Update.

In addition, the inpatient hospital quarterly deductible and outpatient surgery quarterly deductible are now referred to as copays. This change is reflected in your Member Handbook as follows:

- References to these two deductibles have been removed from the "Deductibles" subsection on pages 6-8 in the "Your Costs" section of your Member Handbook, and added to the updated "Copayments" subsection on pages 16-19 of this Benefit Update.
- The following terms are changed as indicated below, wherever they appear in your Member Handbook:
  - "inpatient hospital quarterly deductible" is changed to "inpatient hospital quarterly copay"
  - "outpatient surgery quarterly deductible" is changed to "outpatient surgery quarterly copay"

The "Copayments" subsection on pages 8-10 in the "Your Costs" section of your Member Handbook is deleted and replaced with the following, to reflect the above copay changes:

Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the provider, the type of service you receive and the tier level of the physician or hospital. Copays are always deducted before the individual calendar year deductible is applied (where applicable). Copays do not count toward satisfying the annual calendar year deductibles, coinsurance amounts or out-of-pocket maximums. See the copay chart on pages 18-19 of this Benefit Update for copays for each type of service.

Example: If you are a member of the PLUS Plan and you or a covered dependent go to a physician's office, you or your dependent will be responsible for paying an office visit copay. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is an emergency room copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital quarterly copay applies.

Inpatient Hospital Quarterly Copay
The inpatient hospital quarterly copay applies on a per-person, per-calendar-year-quarter basis. Each time you or a covered dependent is admitted to a hospital, you are responsible for this copay. However, once a covered person pays this copay in any single calendar year quarter, he or she will not have to pay the copay again during that same calendar year quarter. In addition, the inpatient hospital copay is waived for re-admissions that occur within 30 days following a hospital discharge within the same calendar year (even if the admissions occur in different calendar year quarters). This copay does not apply toward the calendar year deductible.

Example 1: If you are admitted to a hospital in January and stay overnight, you will be responsible for paying the inpatient hospital copay. If you are re-admitted to a hospital in March, you will not be responsible for another inpatient hospital copay, as March is in the same calendar year quarter as January. However, if you are re-admitted to a hospital in May, you will incur another inpatient hospital copay.

Example 2: If you are admitted to a hospital at the end of March and then re-admitted in April (within 30 days of your March discharge), you will not be responsible for another inpatient hospital copay. But if you are re-admitted to a hospital in May (more than 30 days from your March discharge), you will incur another inpatient hospital copay.

Example 3: If you are admitted to a hospital at the end of December and then are re-admitted in the beginning of January, you will be responsible for another inpatient hospital copay because the admissions were not in the same calendar year (even though the two admissions occur within 30 days of each other).

Outpatient Surgery Quarterly Copay
The outpatient surgery quarterly copay is a per-person, per-calendar-year-quarter copay. Each time you or a covered dependent has surgery at a hospital, you are responsible for paying this copay. However, once a covered person satisfies the outpatient surgery quarterly copay in any calendar year quarter, he or she will not have to satisfy this copay again during that same calendar year quarter. This copay does not apply toward the calendar year deductible. (Note: When you have outpatient surgery at a freestanding ambulatory surgical facility or at a physician's office, you do not have to pay the outpatient surgery quarterly copay.)

Example: If you have outpatient surgery at a hospital in January, you will be responsible for paying the outpatient surgery copay on the hospital charges. If you have another surgery in March, you will not have to pay another outpatient surgery copay, as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another outpatient surgery copay.

Copays for Medical Services
The chart on pages 18-19 shows the copays you are responsible for with certain types of medical services. The names of the tiers have been assigned by the GIC for use uniformly across all of its health plans. For information about physician tier designations, see page 12 in the "Your Costs" section of your Member Handbook. (Please note that you are not required to select a primary care physician.)

You can also see the following providers at the same copay level as Tier 2 physicians:

- All non-Massachusetts physicians
- Physicians listed in the Massachusetts Physician Tier Listing with the indication that they do not have sufficient data available to allow us to determine any type of scoring—such as those physicians who are new to practice
- Nurse practitioners and physician assistants

Copays for Medical Services

Type of Medical Visit	Copay (when you use a PLUS provider)	Copay (when you use a non-PLUS provider)
☎ Inpatient Hospital Services	Tier 1: $250[1] Tier 2: $500[1] Tier 3: $750[1] The inpatient hospital quarterly copay is waived for re-admissions that occur within 30 days following a hospital discharge, within the same calendar year.	$500. The inpatient hospital quarterly copay is waived for re-admissions that occur within 30 days following a hospital discharge, within the same calendar year.
☎ Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs at a Designated Hospital[2]	$250 (when you use a designated PLUS Tier 2 or Tier 3 hospital)	$500
☎ Quality Centers and Designated Hospitals for Transplants[3]	$250 (when you use a Massachusetts hospital that is a Quality Center or Designated Hospital for Transplants) $500 (when you use a Massachusetts Tier 2 hospital that is not a Quality Center or Designated Hospital for Transplants) $750 (when you use a Massachusetts Tier 3 hospital that is not a Quality Center or Designated Hospital for Transplants)	$250 (when you use a Quality Center or Designated Hospital for Transplants) $500 (when you use a hospital that is not a Quality Center or Designated Hospital for Transplants)
☎ Outpatient Surgery	Tier 1: $110[1] per quarter Tier 2: $110[1] per quarter Tier 3: $250[1] per quarter	$100 per quarter
Emergency Room Charge	$100 (waived if admitted)	$75 (waived if admitted)

1 To find out a hospital's tier designation, see "Appendix C" at the back of your Member Handbook.

2 For a list of these procedures and hospitals, see "Appendix D" at the back of your Member Handbook.

3 For more information regarding Quality Centers and Designated Hospitals for Transplants, call and speak to a UniCare case manager at (800) 442-9300.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

Copays for Medical Services *continued*

Type of Medical Visit	Copay (when you use a PLUS provider)	Copay (when you use a non-PLUS provider)
☎ Outpatient High-Tech Imaging (such as MRIs, CT scans and PET scans) at Hospital and Non-Hospital Locations	$100 per scan; maximum of one copay per day	$75 per scan; maximum of one copay per day
Physician Office Visits	**Tier 1*** (excellent):** ▪ Primary care physician:[1] $15 ▪ Specialty care physician: $25 **Tier 2** (good):** ▪ Primary care physician:[1] $30 ▪ Specialty care physician: $30 **Tier 3* (standard):** ▪ Primary care physician:[1] $35 ▪ Specialty care physician: $45	$30
Services Provided by Nurse Practitioners	$30	$30
☎ Physical Therapy and ☎ Occupational Therapy	$20	$15
☎ Chiropractic Care	$20	$20
Routine Eye Examinations: With an Optometrist With an Ophthalmologist	 $30 See specialty care physician office visit copays above	 $30 $30
Licensed Retail Medical Clinics at Retail Pharmacies	$20	$20

1 Primary care physicians are pediatricians, and physicians specializing in family medicine, general medicine and/or internal medicine. Some primary care physicians may also be specialty care physicians and, if so, may be considered to be specialists in the determination of their tier and copay assignments. This means you will pay the office visit copay for the type of practice the physician has been designated to, regardless of whether you see the physician for a primary care or specialty care visit.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

Reconsideration Process

The subsection, "Expedited Appeals Process" in the "Managed Care Program" section on page 25 of your Member Handbook is now titled, "Reconsideration Process."

Online Plan Resources

Online Access to Medical Information and Plan Resources at www.unicarestateplan.com

The Healthcare Advisor™, a hospital comparison resource, is no longer available at **www.unicarestateplan.com**. To reflect this change to your Member Handbook, the bulleted item titled, "Get help from the Healthcare Advisor™" under the subheading, "Online Access to Medical Information and Plan Resources at **www.unicarestateplan.com**" on page 3 of your Member Handbook, has been deleted. See our link to other hospital comparison resources on our "Health Care Quality Initiatives" page under the "Members" tab at **www.unicarestateplan.com**.

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs—Effective February 1, 2010

Effective February 1, 2010, there will be changes to your copays for outpatient mental health, substance abuse and Enrollee Assistance Program (EAP) visits. The benefits chart on page 89 of your Member Handbook is deleted and replaced with the following to reflect this change:

Covered Services	Network Benefits	Out-of-Network Benefits
Outpatient Care (e, f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)		
Enrollee Assistance Program (EAP)	Up to 3 visits: 100%	No coverage for EAP
	EAP *non-notification penalty* reduces benefit to zero: no benefits paid.	
Individual and Family Therapy	100%, after $20 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Group Therapy	100%, after $15 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Medication Management: (15-30 minute psychiatrist visit)	100%, after $15 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, f)
In-Home Mental Health Care	Full coverage	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, f)
Drug Testing (as an adjunct to Substance Abuse treatment)	Full coverage	No coverage
	Non-notification penalty reduces benefit to zero: no benefits paid.	
Provider Eligibility – Provider must be licensed in one of these disciplines.	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network* and *out-of-network out-of-pocket maximums* do not *cross accumulate*.
(b) *Cross accumulates* with all *out-of-network* mental health and substance abuse benefit levels.
(c) Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.
(d) Out-of-network care that is not preauthorized is subject to financial penalty and retrospective review.
(e) All care requires preauthorization.
(f) All *out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.
(g) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

Please note: The words in italics have special meanings that are given in the Glossary section in Part II on pages 85-86 of your Member Handbook.

Notes

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Important Information Enclosed
Please Read

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P.O. Box 9016
Andover, MA 01810-0916